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BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: AUGARE THOMAS 14210 S. Vermont Avenue #107 Gardena, California 90247 Respiratory Care Practitioner License No. 22838 Respondent.	Case No. 1H 2007 454 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Stephanie Nunez (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Respiratory Care Board of California, Department of Consumer Affairs (Board).

2. On or about February 11, 2003, the Board issued Respiratory Care Practitioner License Number 22838 to Augare Thomas (Respondent). This license was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2010, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code), unless otherwise indicated.

4. Section 3710 of the Code states: "The Respiratory Care Board of California, hereafter referred to as the board, shall enforce and administer this chapter [Chapter 8.3, the Respiratory Care Practice Act]."

5. Section 3718 of the Code states: "The board shall issue, deny, suspend, and revoke licenses to practice respiratory care as provided in this chapter."

6. Section 3750 of the Code states:

"The board may order the denial, suspension or revocation of, or the imposition of probationary conditions upon, a license issued under this chapter, for any of the following causes:

" . . .

"(f) Negligence in his or her practice as a respiratory care practitioner.

". . . ."

"(o) Incompetence in his or her practice as a respiratory care practitioner.

". . . ."

7. Section 3755 of the Code states:

"The board may take action against any respiratory care practitioner who is charged with unprofessional conduct in administering, or attempting to administer, direct or indirect respiratory care. Unprofessional conduct includes, but is not limited to, repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques, and violation of any provision of Section 3750. The board may determine unprofessional conduct involving any and all aspects of respiratory care performed by anyone licensed as a respiratory care practitioner."

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COST RECOVERY

8. Section 3753.5, subdivision (a) of the Code states:

"In any order issued in resolution of a disciplinary proceeding before the board, the board or the administrative law judge may direct any practitioner or applicant found to have committed a violation or violations of law to pay to the board a sum not to exceed the costs of the investigation and prosecution of the case."

9. Section 3753.7 of the Code states:

"For purposes of the Respiratory Care Practice Act, costs of prosecution shall include attorney general or other prosecuting attorney fees, expert witness fees, and other administrative, filing, and service fees."

10. Section 3753.1, subdivision (a) of the Code states:

"An administrative disciplinary decision imposing terms of probation may include, among other things, a requirement that the licensee-probationer pay the monetary costs associated with monitoring the probation."

FIRST CAUSE FOR DISCIPLINE

(Negligence)

11. Respondent is subject to disciplinary action under section 3750, subdivision (f), of the Code in that she was negligent in her practice as a respiratory care practitioner. The circumstances are as follows:

A. In July 2007, Respondent was employed as a respiratory care practitioner at Torrance Memorial Medical Center (TMMC) in Long Beach, California. On or about July 6, 2007, Respondent was responsible for providing respiratory care and treatment to Patient #4049627, an eighty-two year old male who previously had a tracheostomy, was in respiratory failure, and was ventilator dependent.

B. On July 6, 2007, at about 7:39 p.m., Respondent entered an order for the patient to be placed on a ventilator with 100% oxygen. Respondent did not perform or document in the patient's record that a ventilator check was done when the patient was placed on a ventilator.

C. At about 8:26 p.m., the patient's physician ordered that the patient be admitted to the Intensive Care Unit (ICU). At about 8:36 p.m., the patient's physician ordered a chest CT scan. At about 9:00 p.m., Respondent disconnected the patient from the ventilator and put the ventilator on standby mode. Respondent manually ventilated the patient while transporting the patient to the chest CT scanner department.

D. After the chest CT scan was completed, Respondent transported the patient, who was still being manually ventilated, back to the Emergency Room (ER) at about 9:17 p.m. Respondent reconnected the patient to the ventilator. However, she did not turn on the ventilator, but left the ventilator in standby mode, thus depriving the patient of oxygen. Respondent did not perform or document a ventilator check after she reconnected the patient to the ventilator. She did not verify that the ventilator was operating properly. Respondent did not assess and document the patient's condition after transporting him to the ER and placing him on the ventilator. Respondent then left the patient's room.

E. When a nurse entered the patient's room at about 9:20 p.m., she observed that the patient was very pale, his lips were gray, he was unresponsive, and was not breathing. The nurse also observed that the ventilator screen for the patient was in standby mode. The patient was in cardiopulmonary arrest. At about 9:20 p.m., a Code Blue was called which continued until about 9:37 p.m., when the patient was stabilized. Respondent did not document in the patient's record the incident regarding the ventilator standby mode or that a Code Blue was called.

F. The Evita Ventilator logbook summary for the patient's ventilator recorded the following events for July 6, 2007: The patient's ventilator was powered on at 7:39 p.m. Standby mode was activated at 9:00 p.m. when the patient was transported to the CT unit. Standby mode was terminated at 9:20 p.m. when a Code Blue was called.

G. The Mechanical Ventilation Policy (MVP) at TMMC required, among other things, that Respondent record all relevant data on the ventilator flow sheet in the Hospital Information System, document all current ventilator settings, document alarms,

document clinical observations, and evaluate the patient's condition at each system check. She was also required to perform ventilator checks at various times, including after changes in ventilator settings and after transporting a patient. Respondent did not follow these procedures as was required by the hospital's MVP.

H. Respondent was terminated from her employment at TMMC on July 13, 2007.

Negligent Acts

I. Respondent committed acts of negligence regarding the care and treatment of Patient #4049627 on or about July 6, 2007, which included, but were not limited to, the following:

1. Respondent failed to perform and document the initial ventilator check when she placed the patient on the ventilator at about 7:39 p.m.

2. When Respondent returned the patient to the ER, she reconnected the patient to the ventilator, but failed to turn on the ventilator. Respondent left the ventilator in standby mode, thereby depriving the patient of oxygen.

3. Respondent failed to perform or document a ventilator check after she reconnected the patient to the ventilator. She failed to verify that the patient's ventilator was operating properly and was in active mode.

4. Respondent failed to assess and document the condition of the patient after transporting him back to the ER and connecting him to the ventilator.

5. Respondent failed to turn on the ventilator; as a result, the patient went into cardiopulmonary arrest and a Code Blue was called.

6. Respondent failed to follow the hospital's MVP.

7. Respondent failed to document in the patient's record the incident regarding the ventilator standby mode and the subsequent Code Blue.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

12. Respondent is subject to disciplinary action under section 3750,

subdivision (o) of the Code in that she was incompetent in her practice as a respiratory care practitioner. The facts and circumstances, set forth in Paragraph 11 of this Accusation, are incorporated herein by reference.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

13. Respondent is subject to disciplinary action under section 3755 of the Code in that she engaged in unprofessional conduct in her practice as a respiratory care practitioner. The facts and circumstances, set forth in Paragraphs 11 and 12 of this Accusation, are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Respiratory Care Board issue a decision:

1. Revoking or suspending Respiratory Care Practitioner License Number 22838 issued to Aguare Thomas;

2. Ordering Aguare Thomas to pay the Respiratory Care Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

3. Taking such other and further action as deemed necessary and proper.

DATED: April 21, 2008

Original signed by Liane Zimmerman for:
STEPHANIE NUNEZ
Executive Officer
Respiratory Care Board of California
Department of Consumer Affairs
State of California
Complainant